Appendix X
QUEST MEDICAL PLAN
REPORT/REFERRAL TO MED-QUEST DIVISION INVESTIGATOR
RE: SUSPECTED CASES OF MEDICAID FRAUD AND/OR ABUSE

Per QUEST Plan RFPs, cases of suspected fraud and/or abuse must be promptly reported to Med-QUEST Division, Medical Standards Branch Medicaid Investigator. Please submit this report within 30 days of discovery.

TO:	Ronald Kim, Medicaid Investigator Med QUEST Division, Medical Standards Branch P.O. Box 700190 Kapolei, Hawaii 96709-0190	Phone: (808) 692-8114 FAX: (808) 692-8131

QUEST Health Plan: _____	**Report Prepared By:** _____ Name/Title	**Date Prepared:** _____

SOURCE OF COMPLAINT	Name: _____ Position/Title: _____ Phone: _____ FAX: _____
HEALTH PLAN CONTACT *(If different from person preparing this report)*	Name: _____ Position/Title _____ Phone: _____ FAX: _____
SUBJECT *(Check Off)* ☐ **PROVIDER** ☐ **ENROLLEE**	Name: _____ ID No: _____ Specialty: _____ Island: _____
SYNOPSIS/NATURE OF COMPLAINT *Date of Discovery:* _____	
PRELIMINARY INVESTIGATION *(If applicable, include approximate dollars involved)* $ _____	

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ACTION(S) TAKEN BY QUEST PLAN/ DISPOSITION OF CASE *(If applicable, indicate if any legal and/or administrative action taken)*	

APPENDIX Y

Elimination of Barriers to Contracting Between FQHC/RHCs and Health Plans

Health Plan Name _____

1. Does the health plan assure that it will make payments for services to FQHCs and RHCs in its network that are no less than the level and amount of payment which the health plan would make for like services furnished by a provider which is not an FQHC or an RHC?.

2. Identify any FQHC or RHC that has an ownership or control interest in the health plan, as defined in Section 72.400 of RFP-MQD-2006-00xxx.

3. Attach signed attestations from each entity (using the form provided in Appendix Z) identified in paragraph 2 confirming that the identified entities have agreed to participate or will, if requested, participate in the network of any other health plan participating in the programs to provide services to eligible QUEST, QUEST Net, and QUEST ACE recipients, so long as the requesting health plan has offered payment terms that comply with the requirements of Section 60.410 of RFP-MQD-2006-00xxx.

_____

Chief Executive Officer Name

_____

Chief Executive Officer Signature

_____

Date

APPENDIX Z

Elimination of Barriers to Contracting Between FQHC/RHCs and Health Plans

Name of FQHC or RHC: _____

I hereby certify that I have read and understand the requirements of Section 72.400 of RFP-MQD-2006-00xxx and further certify that the above-named entity has agreed to participate or will, if requested, participate in the network of any health plan participating in the programs to provide services to eligible QUEST, QUEST Net, and QUEST ACE recipients, so long as the requesting health plan has offered payment terms that comply with the requirements of Section 60.410 of RFP-MQD-2006-00xxx. I further certify that I am authorized to make this attestation on behalf of the above-named entity.

_____ _____

Name Date

_____

Title